

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445380

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

03/30/2011

NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF HIXSON

STREET ADDRESS, CITY, STATE, ZIP CODE

5798 HIXSON HOME PLACE

HIXSON, TN 37343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=E	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting</p>	F 156	<p>This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	<p>Continued From page 1</p> <p>personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and</p>	F 156	<p>F 156</p> <p>Corrective Action:</p> <p>Facility staff have a meeting set up with the Resident Council for 4/19/11 to discuss Resident Council concerns regarding choices significant to the residents, visitation access to family members, personal items in the rooms and meal time services.</p> <p>Facility Administration will conduct a family meeting on 4/26/11 to discuss any family concerns.</p> <p>Potential:</p> <p>Residents in the facility have the potential to be affected. Family members of residents in the facility have the potential to be affected.</p> <p>Measures:</p> <p>Administrative Staff will send a letter to family members to inform them of facility visitation process by 4/27/11.</p> <p>Resident/family information letter that addresses visitation hours, private telephone access, dining service and personal items allowed in resident rooms will be included in every new admission packet and discussed by the Admissions Coordinator with the resident and/or family beginning 4/27/11.</p>	

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F 156	<p>Continued From page 2 applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident/family/group interview, and a review of facility information provided to residents/families at admission, the facility failed to communicate at admission and during the residents stay at the facility, information regarding visitation hours, access to private telephone conversations, availability of a la carte dining service, and personal items allowed in resident's rooms for twelve of twelve alert, oriented residents in the group interview.</p> <p>The findings included:</p> <p>Observation on the front door of the facility on March 29, 2011, at 7:30 a.m., revealed signage stating facility visitation hours were between 8:00 a.m. and 8:00 p.m. Continued observation revealed the front door was locked preventing access from the outside.</p>	F 156	<p>The Interdisciplinary Team meets with residents/families in a 72 hour care plan meeting to discuss and address concerns and resident status.</p> <p>Activities staff reports any resident concerns brought forth in the resident council meetings to the appropriate department for follow-up.</p> <p>Activities Staff and Social Services Staff will conduct random weekly resident interviews to ask about any concerns related to visitation hours, private telephone access, dining service and personal items allowed in resident rooms.</p> <p>Monitor:</p> <p>Any concerns brought up by resident or family during the 72 hour care plan meeting are addressed with the appropriate staff or department and changes to the resident's plan of care or staff in-service or education is conducted on an as needed basis.</p> <p>Activities staff reports any concerns relayed during the resident council meeting to the Performance Improvement Committee in the monthly performance improvement meeting.</p> <p>Activities and Social Services staff will report the results of the resident interviews to the Performance Improvement Committee in the monthly Performance Improvement Meeting for three months to ensure compliance.</p>		4-27-2011

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F 156	<p>Continued From page 3</p> <p>Family interview on March 29, 2011, at 10:30 a.m., in a resident's room, revealed facility visiting hours are 8:00 a.m. to 8:00 p.m.; the front and side doors remain locked until 8:00 a.m., preventing family members access to residents, and family members' entrance into the building prior to 8:00 a.m. was dependent upon who answered the buzzer (attached at the outside door entrance). Continued family interview revealed if the family member was unable to gain entrance into the facility by 7:30 a.m., the resident could not get dressed in time to eat in the dining room.</p> <p>Group interview on March 29, 2011, at 2:00 p.m., in the Activity Room, with twelve alert, oriented residents revealed the resident's family members were unable to enter the facility prior to 8:00 a.m.</p> <p>Review of facility provided documents (admissions information provided to residents and families) revealed no written information was provided to residents regarding visitation hours or the ability to gain access into the facility for off hour visitation (8 p.m.-8 a.m.).</p> <p>Interview with the Administrator on March 30, 2011, at 2:00 p.m., in the Conference Room, revealed family members were to be allowed entry into the building if they used the buzzer, and confirmed residents and families were not provided with information regarding access to the facility.</p> <p>Resident group interview on March 29, 2011, at 2:00 p.m., in the Activity Room, revealed residents in the group (who did not have a personal telephone in their room), were unaware</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>of a phone available for private use. Resident #1 stated (in the group interview) residents had use of a cordless phone at the previous facility (from which the resident moved to the current facility), but cordless phones were not currently available at this facility for resident use.</p> <p>Interview with the Administrator on March 30, 2011, at 2:05 p.m., in the Conference Room, revealed there was a cordless phone for use at the nurse's station.</p> <p>Review of admission materials revealed no information was provided to residents at the time of admission or thereafter regarding the availability of use of a cordless phone at the nurse's station for private telephone calls.</p> <p>Interview with the Administrator on March 30, 2011, at 2:15 p.m., in the Conference Room, revealed the Administrator depended on the Resident Council President to share with other residents information about the facility, and confirmed residents had not been informed of their right to make private telephone calls through the use of a cordless phone at the nurse's station.</p> <p>Resident group interview on March 29, 2011, from 2:00 p.m. until 3:00 p.m., in the Activity Room, revealed the residents concern regarding personal items, such as picture frames, in the room. Continued group interview revealed residents were asked to take pictures out of picture frames and place the pictures on a small bulletin board in the resident's rooms.</p> <p>Review of admission materials revealed no written information provided to residents about</p>	F 156			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 478Y11

Facility ID: TN3305

If continuation sheet Page 5 of :

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F 156	<p>Continued From page 5</p> <p>what personal items were allowed and not allowed in the room.</p> <p>Interview with the Administrator on March 30, 2011, at 2:27 p.m., in the Conference Room, confirmed residents had not been provided written information about the specific items allowed in the resident's room.</p> <p>Observation of resident #17 on March 28, 2011, at 4:35 p.m., in the day room (next to the dining room) revealed the licensed nurse asked the resident to go (to the resident's room) for a fingerstick. Continued observation revealed the resident became upset about leaving the day room as (the resident) was waiting for the dining room to open for dinner service. Continued observation revealed the resident verbalized (the resident) was afraid the dining room would be closed if (the resident) did not get back to the dining room at a certain hour.</p> <p>Resident group interview on March 29, 2011, from 2:00 p.m. until 3:00 p.m., in the Activity Room, revealed residents were not allowed to eat breakfast in the dining room if they arrived at the dining room after 8:30 a.m. Continued group interview revealed if the residents did not eat in the dining room, they could not order food items from the a la carte menu.</p> <p>Interview with the Certified Dietary Manager (CDM) on March 30, 2011, at 2:45 p.m., in the Conference Room, revealed if residents arrived at the dining room late (after the breakfast had been served), the resident's tray was sent to the floor, and someone would have to bring the tray back to</p>	F 156		

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F 156	Continued From page 6 the dining room. Continued interview with the CDM confirmed no written information regarding dining room services and a la carte services was provided to the residents at admission, or thereafter.	F 156			
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on a review of resident council meeting minutes and interview, the facility failed to resolve resident complaints about bedtime snacks and availability of coffee prior to breakfast. The findings included: Review of resident council monthly meeting minutes from September 2010 until March 2011, revealed at the January 2011 resident council meeting, residents complained about not receiving bedtime snacks. Group interview with twelve alert, oriented residents on March 29, 2011, from 2:00 p.m. until 3:00 p.m., in the Activity Office, revealed residents voiced complaints bedtime snacks were not consistently offered to all residents. Interview with the Staff Development Coordinator (SDC) on March 30, 2011, at 1:30 p.m., at the 100 nurse's station, revealed residents with increased caloric needs and residents with	F 166	F 166 Corrective Action: Facility representatives will meet with the Resident Council on 4/19/11 to discuss bedtime snacks and availability of coffee prior to breakfast. Potential: Residents in the facility have the potential to be affected. Measures: Resident bedtime snacks are provided by the dietary department daily and delivered to the nurses' stations to include the diabetic, nutritional need snacks and house snacks. Dietary staff has nurse initial label that snacks were received. The signed label is then taken to dietary and reviewed by the Certified Dietary Manager on a random basis. The nurse then instructs the certified nursing assistants to pass the bedtime snacks date implemented 4/14/11.		

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F 166	<p>Continued From page 7</p> <p>diabetes were provided individually prepared snacks at bedtime. Continued interview with the SDC revealed those residents (who had no specific nutritional needs) could request a snack, and the Registered Dietitian (RD) would need to speak with the resident to "work the snack into the resident's menu plan".</p> <p>Interview with the Director of Nursing (DON) and Administrator on March 30, 2011, at 2:30 p.m., in the conference room, confirmed bedtime snacks were to be offered to all residents; residents (with no specific nutritional needs) did not have to talk with the RD before they received a bedtime snack, and the resident's complaints about bedtime snacks not offered consistently to all residents was an unresolved grievance.</p> <p>Review of resident council monthly meeting minutes from September 2010 until March 2011, revealed at the October 2010 resident council meeting, residents complained about the lack of coffee prior to 7:30 a.m. Continued review of resident council minutes for December 2010, revealed documentation of feedback from Dietary to the residents: "Dining service starts at 7:30 a.m., no service available prior to that..."</p> <p>Resident group interview on March 29, 2011, at 2:00 p.m., in the Activity Room, revealed residents had been told the Ice Cream Parlor was to be opened, with coffee service, but this had not yet occurred. Continued group interview revealed the residents still were unable to obtain coffee in the morning until their breakfast tray was served.</p> <p>Interview with the Director of Nursing (DON) and</p>	F 166	<p>The dietary staff provides coffee carts to the nursing stations prior to breakfast for nursing staff to offer to residents beginning 4/14/11.</p> <p>Nursing staff was in-serviced regarding providing residents with bedtime snacks by the Director of Nursing on 4/4/11.</p> <p>Nursing Staff was in-serviced on 4/12/11 and 4/13/11 by the Director of Nursing regarding providing bedtime snacks and availability of coffee prior to breakfast. Nursing staff will be in-serviced and education will be provided in new hire orientation. Nursing staff will be in-serviced on or before 4-27-2011. The associates will not be scheduled to work the floor after 4-27-2011 until in-service is completed.</p> <p>Monitor:</p> <p>Activities staff and Social Services staff will conduct random weekly resident interviews to ask about availability of bedtime snacks and coffee. Activities Director or Social Services Director will report results of resident interviews to the Performance Improvement Committee monthly in the Performance Improvement meeting for three months to ensure compliance.</p>	4-27-2011	

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F 166	Continued From page 8	F 166			
F 172 SS=E	<p>Administrator on March 30, 2011, at 2:25 p.m., in the Conference Room, confirmed the residents' concern about coffee was an unresolved grievance.</p> <p>483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS</p> <p>The resident has the right and the facility must provide immediate access to any resident by the following:</p> <p>Any representative of the Secretary;</p> <p>Any representative of the State;</p> <p>The resident's individual physician;</p> <p>The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);</p> <p>The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);</p> <p>The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of</p>	F 172	<p>F 172</p> <p>Corrective Action:</p> <p>Facility staff have a meeting set up with the Resident Council for 4/19/11 to discuss Resident Council concerns regarding choices significant to the residents, visitation access to family members, personal items in the rooms and meal time services.</p> <p>Facility Administration will conduct a family meeting on 4/26/11 to discuss any family concerns including access to the facility and visitation hours.</p> <p>Potential:</p> <p>Residents in the facility have the potential to be affected.</p> <p>Family members of residents in the facility have the potential to be affected.</p>		

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F 172	<p>Continued From page 9 the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, family/group interview, and a review of facility provided documents, the facility failed to ensure residents were granted free access to visitation by family.</p> <p>The findings included: Observation on the front door of the facility on March 29, 2011, at 7:30 a.m., revealed signage stating facility visitation hours were between 8:00 a.m. and 8:00 p.m. Continued observation revealed the front door was locked preventing entrance from the outside.</p> <p>Family interview on March 29, 2011, at 10:30 a.m., in a resident's room; revealed facility visiting hours are 8:00 a.m. to 8:00 p.m.; the front and side doors remain locked until 8:00 a.m., preventing family members access to residents; and the family members' entrance into the building prior to 8:00 a.m. was dependent upon someone answering the buzzer (located on the outside entrance).</p> <p>Group interview on March 29, 2011, at 2:00 p.m., in the Activity Room, with twelve alert, oriented residents revealed the residents family members were unable to enter the facility prior to 8:00 a.m.</p>	F 172	<p>Measures:</p> <p>Administrative Staff will send a letter to family members to inform them of facility visitation process by 4/27/11.</p> <p>Resident/family information letter that addresses visitation hours, private telephone access, dining service and personal items allowed in resident rooms will be included in every new admission packet and discussed by the Admissions Coordinator with the resident and/or family beginning 4/27/11.</p> <p>The Interdisciplinary Team meets with residents/families in a 72 hour care plan meeting to discuss and address concerns and resident status.</p> <p>Activities staff reports any resident concerns brought forth in the resident council meetings to the appropriate department for follow-up.</p> <p>Activities Staff and Social Services Staff will conduct random weekly resident interviews to ask about any concerns related to visitation hours, private telephone access, dining service and personal items allowed in resident rooms.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>Monitor:</p> <p>Any concerns brought up by resident or family during the 72 hour care plan meeting are addressed with the appropriate staff or department and changes to the resident's plan of care or staff in-service or education is conducted on an as needed basis.</p> <p>Activities staff reports any concerns relayed during the resident council meeting to the Performance Improvement Committee in the monthly performance improvement meeting.</p> <p>Activities and Social Services staff will report the results of the resident interviews to the Performance Improvement Committee in the monthly Performance Improvement Meeting for three months to ensure compliance.</p>	4-27-2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

Facility ID: TN3305

If continuation sheet 10A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 172	Continued From page 10	F 172			
F 174 SS=D	<p>Review of facility provided documents (admissions information provided to residents and families) did not address visitation hours.</p> <p>Interview with the Administrator on March 30, 2011, at 2:00 a.m., in the Conference Room, revealed family members were to be allowed entry the building if they used the buzzer.</p> <p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</p> <p>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>This REQUIREMENT is not met as evidenced by: Based on group/resident interview and a review of facility admission materials, the facility failed to ensure one (#1) of seventeen residents reviewed, and other residents without a personal phone, had access to a telephone for private use.</p> <p>The findings included:</p> <p>Resident group interview on March 29, 2011, at 2:00 p.m., in the Activity Room, revealed residents in the group (who did not have a personal telephone in their room), were unaware of a phone available for private use. Resident #1 stated (in the group interview) residents had use of a cordless phone at the previous facility (from which the resident moved to the current facility), but cordless phones were not currently available for use at this facility.</p> <p>Interview with the Administrator on March 30,</p>	F 174	<p>F 174</p> <p>Corrective Action:</p> <p>Director of Nursing met with Resident #1 on 4/14/11 to discuss resident access to cordless phone for private personal phone calls.</p> <p>Facility staff have a meeting set up with the Resident Council for 4/19/11 to discuss Resident Council concerns regarding choices significant to the residents, visitation access to family members, personal items in the rooms and meal time services.</p> <p>Potential:</p> <p>Residents in the facility have the potential to be affected.</p>		

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			<p>Measures:</p> <p>Resident/family information letter that addresses visitation hours, private telephone access, dining service and personal items allowed in resident rooms will be included in every new admission packet and discussed by the Admissions Coordinator with the resident and/or family beginning 4/27/11. Copy of this letter will be provided to current residents prior to 4/27/11.</p> <p>Activities staff reports any resident concerns brought forth in the resident council meetings to the appropriate department for follow-up.</p> <p>Activities Staff and Social Services Staff will conduct random weekly resident interviews to ask about any concerns related to visitation hours, private telephone access, dining service and personal items allowed in resident rooms.</p> <p>Monitor:</p> <p>Activities staff reports any concerns relayed during the resident council meeting to the Performance Improvement Committee in the monthly performance improvement meeting.</p>		

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Event ID: 479Y11

Facility ID: TN3305

If continuation sheet 11 A

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F 174	Continued From page 11 2011, at 2:05 p.m., in the Conference Room, revealed there was a cordless phone for use at the nurse's station. Review of admission materials revealed no information was provided to residents at the time of admission or thereafter regarding the availability of use of a cordless phone at the nurse's station for private telephone calls. Interview with the Administrator on March 30, 2011, at 2:15 p.m., in the Conference Room, revealed the Administrator depended on the Resident Council President to share with residents information about the facility, and confirmed residents had not been informed of their right to make private telephone calls through the use of a cordless phone at the nurse's station.	F 174	Activities and Social Services staff will report the results of the resident interviews to the Performance Improvement Committee in the monthly Performance Improvement Meeting for three months to ensure compliance.	4-27-2011
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to assess one resident (#4) for the use of a restraint of seventeen residents reviewed. The findings included: Resident #4 was admitted to the facility on	F 221	F 221 Corrective Action: #1) The Initial Restraint Assessment for resident #4 for the blanket roll for scoop (bolster) mattress was completed by the Interdisciplinary Team on 4-13-11. Potential to be Affected: #2) Residents with blanket rolls to bolster side mattresses have the potential to be affected.	

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F 221	Continued From page 12 February 17, 2011, with diagnoses including Fracture Femur, Cerebral Vascular Accident, Osteoporosis, and Mental Disorder. Medical record review of the Interim Care Plan revealed the resident had a history of falls, was at risk for falls and on March 17, 2011, the facility implemented a low bed with a pressure sensitive alarm to the bed. Continued review revealed the facility implemented a scoop mattress and fall mats on February 27, 2011, and on March 14, 2011, implemented a blanket roll to the edges of the scoop mattress until foam rolls (bolsters) were available. Medical record review revealed no assessment of the bolsters as a restraint. Observation on March 30, 2011, at 10:45 a.m., revealed the resident in bed with a pressure alarm low bed, scoop mattress with bolsters to the bed and mats on the floor at bedside. Interview with the Director of Nursing and the Corporate Nurse on March 30, 2011, at 1:30 p.m., in the conference room, confirmed the bolsters did restrict the residents movement and had not been assessed as a restraint.	F 221	Measures : #3) Initial restraint assessments will be completed upon initiation of a restrictive device, then updated/reviewed quarterly and with a significant change status according to the Minimum Data Set schedule. Director of Nursing or Assistant Director of Nursing will perform monthly audits to check completion of restraint assessments. The Interdisciplinary Team will be in-serviced by Nursing Administration on 4/13/11 on process of completing restraint assessments. Monitored:		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC. POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	#4) Monthly audits for completion of resident restraint assessments will be conducted by Director of Nursing or Assistant Director of Nursing and results reported to the Performance Improvement Committee for three months for compliance.		4-27-2011

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F 226	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, a review of facility provided documents and facility policy review, the facility failed to correctly implement the facility policy on the investigation of allegations of abuse and neglect for two (#14 and #13) of seventeen sampled residents.</p> <p>The findings included:</p> <p>Review of facility provided documents revealed on February 25, 2011, resident #9 reported an allegation of abuse of resident #14 by CNA (Certified Nursing Assistant) #1. Review of facility provided documents revealed "Facility Investigation and Response...Person designated to investigate and follow-up with Concern... (Registered Nurse #1)...Date/Time of initial contact with concerned party...2/25/2011-1100 (11:00 a.m.)...Investigation Findings...No abuse discovered at this time...Buddy System on (resident #9 and #14) in place per staffing assignment sheet. Follow-up to continue c (with) on-going monitoring per charge nurses."</p> <p>Review of facility provided documents revealed no written statement was obtained from CNA #1, other CNA's working with CNA #1, or other residents under CNA #1's care.</p> <p>Review of facility provided documents revealed on February 28, 2011, resident # 13 reported concerns about pain management, and concerns about lack of assessment of the resident's incision site and a swollen leg. Continued review</p>	F 226	<p>F 226</p> <p>Corrective Action:</p> <p>Facility unable to complete corrective action for resident #13, she was discharged to home prior to the annual survey.</p> <p>Facility unable to complete corrective action for residents # 9 and #14 due to the time lapse from the report on the concern and comment to survey. Certified Nursing Assistant #1 was re-assigned on 2/25/11. Certified Nursing Assistant was in-serviced on 3/30/11 by the Staff Development Coordinator on Resident rights and resident abuse.</p> <p>Potential:</p> <p>Residents in the facility have the potential to be affected.</p> <p>Measures:</p> <p>The Staff Development Coordinator began in-service education for staff regarding Resident Rights and Resident abuse on 3/30/11.</p> <p>The Director of Nursing conducted in-service education on 4/4/11 for all staff regarding resident abuse and/or neglect investigation, abuse regulations, abuse definitions, reporting alleged abuse, witness interview policy. Review of concern and comment form and how to complete.</p>		

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F 226	<p>Continued From page 14</p> <p>of facility provided documents revealed RN #1 was assigned to investigate the allegations. Review of "Facility Investigation and Response", dated March 1, 2011, revealed "Investigation Findings...Resident has pain meds order and charge nurse to give routinely. Staff educated and agrees to provide TLC (tender loving care) often and consistently..." Continued review of facility provided documents revealed resident #13's concerns were not investigated until March 30, 2011.</p> <p>Review of facility policy "Abuse and/or Neglect Investigation...Policy...Residents have the right to live at ease in a safe environment without the fear of relation when suspected abuse and/or neglect is reported. All reports of abuse will be promptly and thoroughly investigated and shall remain confidential...Policy Interpretation and Implementation...1. When an incident or suspected incident of resident abuse and/or neglect is reported, the administrator will appoint a representative to investigate the occurrence. 2. The representative will utilize the Incident Investigation questionnaire to complete the investigation. 3. The representative will review the Incident Report for completeness and assure that the physician and responsible parties have been notified of the circumstance...5. The investigation shall include a written summary of...Interviews with staff members on all shifts having contact with the resident at the time of the incident...An interview with other residents who received care or services from the alleged perpetrator...A review of all circumstances surrounding the incident."</p> <p>Interview with the Administrator and Director of Nursing on March 30, 2011, at 9:00 a.m., in the</p>	F 226	<p>The Director of Nursing conducted in-service education on 4/13/11 with department managers on abuse/neglect investigation and witness interview policy.</p> <p>The Director of Nursing conducted in-service education with staff on 4/13/11 regarding abuse and neglect.</p> <p>Associates will be in-serviced and education will be provided in new hire orientation. Associates will be in-serviced on or before 4-27-2011. The associates will not be scheduled to work the floor after 4-27-2011 until in-service is completed.</p> <p>Concern and Comment forms to be reviewed for completion in Department Head Morning Meeting and a log will be maintained by the Social Services Director which will include documentation of investigation follow-up.</p> <p>Monitor:</p> <p>The Social Services Director will review the Concern and Comment Log for completion of investigation and follow-up in the Monthly Performance Improvement Meeting monthly for three months to ensure compliance.</p>	4-27-2011

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F 226	Continued From page 15 Conference Room, confirmed the February 25, 2011, allegation of abuse was not investigated; the February 28, 2011, allegation of lack of treatment was not investigated until March 30, 2011; and the facility policy on investigating allegations of abuse and neglect was not correctly implemented.	F 226			
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident/group interview for twelve of twelve residents, the facility failed to provide choices significant to the residents in the areas of visitation access to family members, personal items in the room and mealtime services. One (#17) of seventeen residents reviewed expressed concern due to a fear (the resident) would miss a meal in the dining room and not be allowed in the dining room at a later time to eat. The findings included: Observation on the front door of the facility on March 29, 2011, at 7:30 a.m., revealed signage stating facility visitation hours were between 8:00 a.m. and 8:00 p.m. Continued observation revealed the front door was locked from the	F 242	F 242 Corrective Action: Facility staff have a meeting set up with the Resident Council for 4/19/11 to discuss Resident Council concerns regarding choices significant to the residents, visitation access to family members, personal items in the rooms and meal time services. Nursing spoke with resident number 17 on April 20, 2011, and reassured him if he has to leave the dining room for a period of time that he will be able to return to the dining room. Potential: Residents in the facility have the potential to be affected.		

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F 242	<p>Continued From page 16 outside.</p> <p>Family interview on March 29, 2011, at 10:30 a.m., in a resident's room, revealed facility visiting hours are 8:00 a.m. to 8:00 p.m.; the front and side doors remain locked from 8 p.m. until 8:00 a.m., preventing family members access to visiting residents, and the family members' entrance into the building prior to 8:00 a.m. was dependent upon someone answering the buzzer (located on the outside of the door requiring response from inside to allow access to unlock for entry).</p> <p>Group interview on March 29, 2011, at 2:00 p.m., in the Activity Room, with twelve alert, oriented residents revealed the resident's family members were unable to enter the facility prior to 8:00 a.m.</p> <p>Review of facility provided documents (admissions information provided to residents and families) did not address visitation hours.</p> <p>Interview with the Administrator on March 30, 2011, at 2:00 p.m., in the Conference Room, revealed family members were to be allowed to enter the building when they used the buzzer.</p> <p>Resident group interview on March 29, 2011, from 2:00 p.m. until 3:00 p.m., in the Activity Room, revealed a concern residents had regarding being allowed to place personal items, such as picture frames, in the room. Continued group interview revealed residents were asked to remove pictures out of picture frames and place the pictures on a small bulletin board in the resident's room.</p>	F 242	<p>Measures:</p> <p>Meeting with Resident Council members on 4/19/11 with facility staff to address concerns of significant choices to the residents, visitation access to family members, personal items in the rooms and mealtime services.</p> <p>Administrative Staff will send a letter to family members to inform them of facility visitation process by 4/27/11.</p> <p>Resident/family information letter that addresses visitation hours, private telephone access, dining service and personal items allowed in resident rooms will be included in every new admission packet and discussed by the Admissions Coordinator with the resident and/or family beginning 4/27/11.</p> <p>Activities Staff and Social Services Staff will conduct random weekly resident interviews to ask about any concerns related to visitation hours, private telephone access, dining service and personal items allowed in resident rooms.</p> <p>Monitor:</p> <p>Activities and Social Services staff will report the results of the resident interviews to the Performance Improvement Committee in the monthly Performance Improvement Meeting for three months to ensure compliance.</p>	4-27-201	

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F 242	<p>Continued From page 17</p> <p>Review of admission materials revealed no written information provided to residents about what personal items were allowed and not allowed in the room.</p> <p>Interview with the Administrator on March 30, 2011, at 2:27 p.m., in the Conference Room, confirmed residents had not been provided written information about the specific items allowed in the resident's room.</p> <p>Observation of resident #17 on March 28, 2011, at 4:35 p.m., in the day room (next to the dining room) revealed the licensed nurse asked the resident to go (to the resident's room) for a fingerstick. Continued observation revealed the resident became upset about leaving the day room as (the resident) was waiting for the dining room to open for dinner service. Continued observation the resident verbalized (the resident) was afraid the dining room would be closed if (the resident) did not get to the dining room at a certain hour.</p> <p>Resident group interview on March 29, 2011, from 2:00 p.m. until 3:00 p.m., in the Activity Room, revealed residents were not allowed to eat breakfast in the dining room if they arrived at the dining room after 8:30 a.m. Continued group interview revealed if the residents did not eat in the dining room, they could not order food items from the a la carte menu.</p> <p>Interview with the Certified Dietary Manager (CDM) on March 30, 2011, at 2:45 p.m., in the Conference Room, revealed if residents arrived at the dining room late (after the breakfast had been</p>	F 242			

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F 242	Continued From page 18 served), the resident's tray was sent to the floor, and someone would have to bring the tray back to the dining room. Continued interview with the CDM confirmed no written information regarding dining room services and a la carte services was provided to the residents at admission, or thereafter.	F 242			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide medically related social services for one resident (#2) of seventeen residents reviewed. The findings included: Resident #2 was admitted to the facility on March 16, 2011, with diagnoses including Cerebral Vascular Accident, Hypertension, and Dysphagia. Medical record review of the Admission orders dated March 16, 2011, revealed the resident was a Full Code. Medical record review revealed no Physician Orders for Scope of Treatment completed (POST	F 250	F 250 Corrective Action: The Physician Orders for Scope of Treatment (POST) form for resident #2 was completed by the resident's responsible party on April 14, 2011. Potential: Residents admitted to the facility have the potential to be affected. Measure: Social Services Director will complete a 100% audit of resident's POST forms for completion by 4/18/11. The POST forms will be completed during the admission process. The Social Services Director was in- serviced on the POST form completion process by the Executive Director on April 15, 2011. Health Information Management Director performs an audit of new admits charts that include completion of the POST form and reports results to the Executive Director.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 19 form).	F 250	Monitor:	4-27-2011
F 279 SS=D	Medical record review of a Social Service note dated March 18, 2011, revealed "...Also reviewed POST form with (daughter) who states...will sign it when...comes in today in regards to (resident's) wishes." Interview with the Social Services Director on March 30, 2011, at 7:45 a.m., in the conference room confirmed no follow up had been provided by the Social Service Director with the resident and or daughter to determine code status. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	Social Services Director will report status of new admit POST forms in the monthly Performance Improvement Meeting monthly for three months to ensure compliance.	
			F 279 Corrective Action: #1) Resident #4's comprehensive care plan was updated 3-31-11 by Regional Director of Clinical Services. Potential: #2) Residents with interim care plans have the potential to be affected.	

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F 279	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update the care plan for one resident (#4) of seventeen residents reviewed. Resident #4 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur, Cerebral Vascular Accident, Osteoporosis, and Mental Disorder. Medical record review of the Interim Care Plan revealed the resident had a history of falls and was at risk for falls; March 17, 2011, the facility implemented low bed with a pressure sensitive alarm to the bed. Continued review revealed the facility implemented a scoop mattress and fall mats on February 27, 2011, and March 14, 2011, blanket roll to edge of scoop mattress until foam roll (bolsters) available. Medical record review of the care plan dated March 29, 2011, revealed the scoop mattress, floor mats, bolsters to bed were not addressed on the care plan. Interview with the Director of Nursing and the Corporate Nurse on March 30, 2011, at 1:30 p.m., in the conference room, confirmed the care plan was not updated to reflect the current interventions to prevent an injury from a fall.	F 279	Measures: #3) Upon completion of the comprehensive care plan for falls, the care plan coordinator will review the interim care plan interventions to ensure that the interventions are dated and carried over to the comprehensive care plan. Care plan coordinator will be in-serviced on 4/13/11 by Director of Nursing regarding comparison of interim care plan fall interventions to comprehensive care plan. Director of Nursing will review Care Plan Comparison Form completed weekly by the Care plan coordinator to audit that fall interventions are carried over from the interim to the comprehensive care plan. Monitor: #4) Director of Nursing will report findings of review of Care Plan Comparison Form to Performance Improvement Committee monthly for three months for compliance.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			4-27-2011

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F 281	<p>Continued From page 21</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a prescription refill timely for one resident (#4) of seventeen residents reviewed. For one (#6) of seventeen residents, the facility failed to complete pain assessments per protocol; failed to promptly transcribe onto the Medication Administration Record an order for antibiotic treatment, and failed to document administration of the antibiotic medication.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur, Cerebral Vascular Accident, Osteoporosis and Mental Disorder.</p> <p>Medical record review of a Physician's order dated February 17, 2011, revealed "...Duragesic 12 mcg/hr (micrograms/hour) 1 patch top (topical) q (every) three days..."</p> <p>Medical record review of a Nurse's note dated March 21, 2011, at 2:00 p.m., revealed "waiting for pharmacy to send Duragesic Patch (pain medication) 12 mcg. Order written for patch to be applied up arrival from pharmacy."</p> <p>Medical record review of the Nurse's note dated March 21, 2011, at 11:00 p.m., Night shift notified to apply Duragesic patch..."</p>	F 281	<p>F 281</p> <p>Corrective Action:</p> <p>The Duragesic patch for Resident #4 was received from the pharmacy and placed on the resident on 3/22/11 prior to the survey. The resident has a pain assessment every shift utilizing the 0-10 pain scale with results documented on the Medication Administration Record.</p> <p>The pain assessment for Resident #6 utilizing the 0-10 pain scale was added to the Medication Administration Record every shift on 4/1/11.</p> <p>Cipro order for Resident #6 was clarified with the physician on 3/27/11 prior to the survey and transcribed to the Medication Administration Record. Urinalysis was repeated for this resident on 3/29/11.</p>		

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F 281	<p>Continued From page 22</p> <p>Medical record review of the Pharmacy shipment order dated March 22, 2011, revealed the facility received the Duragesic patch at 4:09 p.m.</p> <p>Medical record review of the Nurse's notes for March 21, 2011, through March 22, 2011, revealed no documentation of any signs or symptoms of pain.</p> <p>Interview with the Director of Nursing on March 29, 2011 at 10:00 a.m., in the conference room, revealed the Pharmacy needed a new prescription from the Physician to refill the medication and there was a twenty-four hour delay in receiving the medication.</p> <p>Resident #6 was admitted to the facility on February 15, 2011, with diagnoses including Chronic Pain Syndrome. Medical record review of nurse's notes, dated March 20, 2011, revealed "Resident is complaining of neck pain..."</p> <p>Medical record review of current physician's orders revealed a current order for Norco (pain medication) 5 mg-325 mg (milligrams) 1 every four hours as needed for breakthrough pain.</p> <p>Medical record review revealed a pain assessment was completed on the resident on February 15, 2011. Continued medical record review of the February and March, 2011, MARS (Medication Administration Records) revealed no further pain assessments.</p> <p>Medical record review of the resident's March 2011 MAR (Medication Administration Review) revealed no documentation the resident was administered pain medication on March 20, 2011.</p>	F 281	<p>Potential:</p> <p>Residents at risk for pain have the potential to be affected. Residents with medication orders have the potential to be affected.</p> <p>Measures:</p> <p>The Director of Nursing notified the Pharmacy of the lapse in Prescription for the resident on 3/23/11. The Pharmacy is now sending the Director of Nursing a Class 2, 3, 4, 5 Prescription Register weekly so that the facility will know which prescriptions will need refills soon. The Pharmacy is also faxing to the</p> <p>Director of Nursing Monday – Friday a list of prescriptions sent to the physician for signature that still needs follow-up. The Director of Nursing or Assistant Director of Nursing will review the pharmacy reports weekly and notify the physician of any needed prescriptions.</p>		

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			<p>Every resident April Medication Administration Record was checked by Nursing Administration on 3/31/11 for the presence of a pain assessment every shift utilizing 0-10 scale.</p> <p>The Director of Nursing or Assistant Director of Nursing will perform weekly audits for three months to assess that each resident has a pain scale on the Medication Administration Record and is being documented every shift.</p> <p>Medication orders are to be faxed to the pharmacy. After hours, the nurse is to call the pharmacy and tell them that they are faxing a new order. The nurse is to place the medication order fax confirmation copy and place it in the order checks notebook. The nurse is to sign off that this medication order was transcribed to the Medication Administration Record. During shift change report, the off-going nurse will report off with the on-coming nurse what new orders were</p>		

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet

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			<p>received. The on-coming nurse will review the new orders in the notebook and will sign that they also checked the order for proper transcription. This process will be repeated for the next shift, so that three consecutive shifts are checking the medication orders for proper transcription to the medication administration record.</p> <p>The Director of Nursing provided in-service education to the licensed nurses on 4/4/11 that included: ordering medications timely, notifying the Director of Nursing for any unavailable medication, use of the Emergency Medication box, the pain level is to be assessed every shift and documented on the medication administration record.</p> <p>The Director of Nursing will in-service licensed nurses regarding medication order transcription process beginning 4/14/11.</p>		

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F 281	<p>Continued From page 23 after complaining of pain.</p> <p>Interview with the Director of Nursing on March 30, 2011, at 3:02 p.m., in the Library, revealed the facility protocol is to assess a resident's pain every shift by documenting the level of pain on the MAR.</p> <p>Interview with the Director of Nursing on March 30, 2011, at 3:05 p.m., in the Library, confirmed the nurse did not document administering pain medication after the resident complained of neck pain, the nurse failed to promptly transcribe the antibiotic order; and the resident's level of pain was not assessed every shift on the February and March, 2011 MARS.</p> <p>Medical record review of nurse's notes revealed on March 17, 2011, revealed the resident was transferred to the emergency room at 5:05 p.m., due to a temperature of 100 degrees Fahrenheit, nausea and vomiting, and poor food intake during the 7:00 a.m. to 3:00 p.m. shift. Continued review of nurse's notes revealed the resident returned to the facility on March 18, 2011, at 1:00 a.m., with a physician's order for "Cipro (antibiotic) 500 mg (milligrams) tab (tablet) PO (orally) 1 tab BID (twice a day) for UTI (urinary tract infection)."</p> <p>Medical record review of the March 2011 Medication Administration Record (MAR) (computerized print out) revealed the Cipro order was handwritten on the MAR, and there was no documentation the resident received the Cipro until March 27, 2011.</p> <p>Medical record review of physician's orders revealed a "Fax Order Request/Notification Form", noted as "priority" on March 27, 2011, at 7:55 a.m. Continued review of the "Fax Order Request ..." revealed "Pt. (patient) was Dx</p>	F 281	<p>An in-service education session for all licensed nurses is scheduled for 4/27/11 with the pharmacy to review pharmacy/drug ordering process.</p> <p>Licensed nurses will be in-serviced and education will be provided in new hire orientation. Licensed nurses will be in-serviced on or before 4-27-2011. The associates will not be scheduled to work the floor after 4-27-2011 until in-service is completed.</p> <p>Director of Nursing, Assistant Director of Nursing or Weekend Supervisor will review order checks notebook daily for three months to ensure that the nurses are completing order checks.</p> <p>Monitor:</p> <p>The Director of Nursing will report results of the prescription checks, pain scale audits order review checks to the Performance Improvement Committee during the monthly Performance Improvement Meeting for three months.</p>		4-27-2011

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F 281	Continued From page 24 (diagnosed) c (with) UTI and Cipro ordered 3/18/11 500 mg PO BID. Pt has not been given Cipro. Need new orders please. Thank you." Medical record review of physician's orders revealed a clarification order was obtained on March 27, 2011, at 3:11 p.m., for Cipro 500 mg 1 orally twice a day "till all gone". Interview with the Director of Nursing on March 29, 2011, at 10:45 a.m., in the conference room, confirmed the Cipro order was not transcribed to the March 2011 MAR until the clarification order was obtained on March 27, 2011.	F 281			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide showers as requested for one resident (#7) of seventeen residents reviewed. The findings included: Resident #7 was admitted to the facility on August 18, 2009, with diagnoses including End Stage Renal Disease, Diabetes, blindness, and Hypertension. Medical record review of the Minimum Data Set dated March 20, 2011, revealed the resident was able to complete the interview and required	F 312	F 312 Corrective Action: #1) Resident #7 discussed shower schedule with Director of Nursing on 3/31/11 and resident reported that she prefers to shower on days opposite of her dialysis. Potential: #2) Residents in the facility have the potential to be affected. Measures: #3) Director of Nursing reviewed shower schedule on 4/13/11 to ensure all residents are included.		

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F 312	Continued From page 25 assistance with hygiene. Medical record review of the Monthly Flow Report for the Month of February revealed the resident received a total of 6 showers. Medical record review of the Monthly Flow Report for the March 2011, revealed the resident received 2 showers, with the last shower dated March 14, 2011. Interview with the resident on March 30, 2011, at 10:50 a.m., in the library confirmed the resident did not receive showers as requested. Interview on March 30, 2011, with the Director of Nursing and the Corporate Nurse in the conference room, confirmed the residents are to be showered 2-3 times a week and as requested or needed by the resident.	F 312	The Staff Development Coordinator in- served nursing staff on 3/30/11 regarding shower schedules to be followed per facility policy. The Director of Nursing in-served nursing staff on 4/4/11 on resident shower schedule. Nursing staff will be in-served and education will be provided in new hire orientation. Nursing staff will be in-served on or before 4-27-2011. The associates will not be scheduled to work the floor after 4-27-2011 until in-service is completed. Showers are to be documented in RITA. The charge nurse is to be notified of any resident refusal of showers and document the refusal on the 24 hour report. Revision of shower schedule as needed to accommodate residents needs/wishes.		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to implement interventions to prevent an injury from a fall/fracture of the right elbow resulting in harm to resident #4 of seventeen residents reviewed.	F 323	The Director of Nursing or Assistant Director of Nursing will print and review RITA documentation twice weekly for three months to ensure residents are receiving showers as scheduled. Monitor: #4) The Director of Nursing will report findings of RITA documentation review regarding showers to Performance Improvement Committee during monthly meeting for three months.		4-27-2011

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F 323	<p>Continued From page 26</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on February 17, 2011, with diagnoses including Fracture Femur, Cerebral Vascular Accident, Osteoporosis and Mental Disorder.</p> <p>Medical record review of the Physician Recapitulation Orders dated February 17, 2011 revealed "...NWB RLE(non weight bearing Right Lower Extremity)..."</p> <p>Medical record review of a Fall Risk Assessment dated February 17, 2011, revealed the resident was high risk for falls.</p> <p>Medical record review of the Interim Care Plan dated February 17, 2011, revealed the facility had implemented a low bed with a pressure sensitive alarm to the bed.</p> <p>Medical record review of a Nurse's note date February 26, 2011, revealed "Pt (patient) found on knees upon entering room by staff. Bed alarm ringing...both knees sl (slightly) red, no open areas noted. No c/o (complaints) of pain..."</p> <p>Medical record review of the fall investigation dated February 26, 2011, revealed "...Resident demonstrated use of call light. Discontinue TED (anti-embolism hose) hose..."</p> <p>Medical record review of a Nurse's note dated February 27, 2011, at 5:20 a.m. revealed "Resident found on the floor by...bed 'I thought I was at home'...does c/o(complain of) rt (right) elbow pain. Moves arms freely ..."</p>	F 323	<p>F 323</p> <p>Corrective Action:</p> <p>Resident #4 was assessed for fall risk upon admission and currently has the following interventions in place to help reduce falls: she is on Physical and Occupational Therapy caseloads, she utilizes a low bed with parameter mats, scoop (bolster-sided) mattress with blanket roll, call-light in reach, nonskid footwear and she is on the falling star program. Resident has had three falls since admission. The first fall was 2/26/11, the new interventions implemented post-fall were re-education to utilize the call-light for assistance, for which resident expressed understanding. Resident also discontinued TED hose which would prevent her from sliding on the floor due to the slick material of the TED hose. The second fall was on 2/27/11 and a scoop (bolster-sided) mattress and parameter mats to bedside were</p>		

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			<p>implemented. The third fall was on 3/12/11 and the new intervention was to add a blanket roll to scoop (bolster-sided) mattress. She has been free from falls since 3/12/11.</p> <p>Potential:</p> <p>Residents at risk for falls have the potential to be affected.</p> <p>Measures:</p> <p>Residents are assessed for fall risk upon admission, after each fall, with each significant change in status and quarterly with the Minimum Data Set assessment. Interventions are implemented for each resident according to individual need.</p>		

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F 323	<p>Continued From page 27</p> <p>Medical record review of the Physician's order dated February 27, 2011, revealed "x-ray of rt elbow stat (immediately). Fall pads to floor around bed."</p> <p>Medical record review of the x-ray report dated February 27, 2011, revealed "...Slightly distracted Olecranon (elbow) fracture..."</p> <p>Medical record review of the fall investigation dated February 27, 2011, revealed the facility implemented a scoop mattress and mats to the floor upon the resident's return to the facility.</p> <p>Medical record review of a Nurse's note dated March 9, 2011, revealed "pt (patient) NPO (nothing by mouth) (after) midnight...Due to surgery tomorrow."</p> <p>Medical record review of a Nurse's note dated March 11, 2011, revealed the resident "returned from (local hospital) after surgery..."</p> <p>Observation on March 30, 2011, at 10:45 a.m, revealed the resident in bed with pressure alarm low bed, scoop mattress with bolsters to the bed and mats on the floor at bedside.</p> <p>Interview with the Director of Nursing and the Corporate Nurse on March 29, 2011, at 1:30 p.m., in the conference room, confirmed on February 26, 2011, the resident fell from the bed with no injury and the facility removed the TED hose and provided education on use of the call light. Continued interview confirmed the facility failed to implement interventions to prevent an fall/injury after the fall on February 26, 2011, and on February 27, 2011, the resident sustained a second fall from the bed resulting in a fracture to</p>	F 323	<p>Charge nurses implement new fall reduction interventions post fall. The weekend supervisor and nurse on call are additional resources that the nurse may utilize as needed for questions and concerns after hours. We also put fall interventions on the care guide for the C.N.A.'s. IDT reviews and follows up on falls Monday through Friday during clinical event meeting.</p> <p>Residents are discussed by the Interdisciplinary Team after each fall and care planned interventions are reviewed and revised as needed.</p>		4-27-2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445380	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/30/2011
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HIXSON			STREET ADDRESS, CITY, STATE, ZIP CODE 5798 HIXSON HOME PLACE HIXSON, TN 37343		
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			<p>The Director of Nursing provided in-service education to nursing staff on 4/4/11 to review falls management, fall risk assessment, falling star program, risk factors for falls, additional interventions and approaches to decrease the risk of falls and investigation of a resident fall. Licensed Nurses will be in-serviced and education will be provided in new hire orientation. Licensed Nurses will be in-serviced on or before 4-27-2011. The associates will not be scheduled to work the floor after 4-27-2011 until in-service is completed. Fall intervention devices are kept in supply room where the charge nurse has access. The Director of Nurses or Assistant Director of Nurses reviews the Incident Follow-up and Recommendation Form to assess that new interventions were implemented and effective after a fall.</p> <p>Monitor: The Director of Nurses discusses falls and trends with the Interdisciplinary Team in the monthly Performance Improvement Meeting.</p>		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

Facility ID: TN3305

If continuation sheet 28A

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F 323	Continued From page 28	F 323		
F 332 SS=E	<p>the right elbow that required surgical repair resulting in harm.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to ensure medications were administered correctly for three residents (#16, #15, #9) of twelve residents observed on medication pass resulting in a medication error rate of 8%.</p> <p>The findings included:</p> <p>Observation on March 29, 2011, at 9:15 a.m., with Licensed Practical Nurse (LPN #1), on the 100 hall, revealed the following medication errors: LPN #1 administered Iron (Ferrous Sulfate) 325 mg. (milligrams) to resident #16. Review of the physician's orders dated March 22, 2011, revealed, "...Ferrous Sulfate (Iron) 300 mg. p.o. (by mouth)..."</p> <p>LPN #1 administered Lasix 20 mg. to resident #16. Review of the physicians orders dated March 22, 2011, revealed, "...Lasix 40 mg. one q (every) a.m..."</p> <p>Interview with LPN #1 on March 29, 2011, at 9:40 a.m., on the 100 hall, confirmed Ferrous Sulfate 300 mg. and Lasix 40 mg. were not administered</p>	F 332	<p>F 332</p> <p>Corrective Action:</p> <p>#1) Unable to complete corrective action for resident #16 who received 325mg of ferrous sulfate. He showed no signs or symptoms of adverse effect due to receiving 325mg of ferrous sulfate instead of 300mg ferrous sulfate. LPN #1 administered another 20mg of lasix to resident #16 on March 29, 2011 so that his total dose received was 40mg as ordered.</p> <p>Resident #15 was given another 10 units of Novolog Insulin on 3/29/11 by LPN #2 is an RN to equal the 20 units ordered by the physician.</p> <p>Corrective action for resident #9 who had received omeprazole 20mg by LPN#3 after eating breakfast, physician order was changed on 3/30/11 to reflect giving omeprazole prior to breakfast.</p>	

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F 332	<p>Continued From page 29 as ordered.</p> <p>Observation of a medication pass on March 29, 2011, at 5:30 p.m., with LPN #2, on the 100 hall, revealed LPN #2 administered Novolog Insulin 10 units to Resident #15. Review of the physician's orders dated March 2011, revealed Novolog Insulin 20 units for blood sugars above 400 and notify the Medical Doctor.</p> <p>Interview with LPN #2 on March 29, 2011, at 6:30 p.m., at the 100 hall nursing station confirmed 10 units of Novolog Insulin was administered instead of 20 units. Continued interview confirmed the physician had been notified of an elevated blood sugar over 400 and LPN #2 had not received a return phone call from the physician. Resident #9 was admitted to the facility on October 12, 2007, with diagnoses including Schizophrenia, Hypertension, Difficulty Walking.</p> <p>Medical record review of the Physician Recapitulation orders for the month of March 2011, revealed " ...Omeprazole (Gastric Reflux Medication) 20 mg cap I cap per mouth twice daily.</p> <p>Observation on March 29, 2011, at 8:15 a.m., during the medication pass revealed Licensed Practical Nurse (LPN) #3 administered Omeprazole 20 mg by mouth.</p> <p>Interview with LPN #3 on March 29, 2011, at 10:30 a.m., confirmed the resident had eaten breakfast prior to the administration of Omeprazole 20 mg.</p>	F 332	<p>Potential:</p> <p>#2) Residents receiving medications have the potential to be affected.</p> <p>Measure:</p> <p>#3) Director of Nursing in-serviced licensed nursing staff on 4/4/11 regarding five rights of medication administration. Licensed nurses will be in-serviced and education will be provided in new hire orientation. Licensed nurses will be in-serviced on or before 4-27-2011. The associates will not be scheduled to work the floor after 4-27-2011 until in-service is completed. Director of Nursing provided one-on-one education with LPN #1, LPN #2 is an RN and LPN #3 regarding medication administration to include the five rights of medication administration on 4/13/11.</p>		

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			<p>Nursing Administration or Pharmacy Staff will conduct medication pass observations with medication nurses weekly for three months beginning 4/13/11.</p> <p>Monitor:</p> <p>Director of Nursing will report results of medication pass observations to the Performance Improvement Committee during monthly Performance Meeting for three months.</p>		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 479Y11

Facility ID: TN3305

If continuation sheet 30A

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F 332	Continued From page 30	F 332			
F 333 SS=D	<p>Review of the package insert revealed "... should be taken before eating..."</p> <p>Interview with the Corporate Nurse on March 30, 2011, at 2:15, in the conference room, confirmed Omeprazole is to be given before meals.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure one (#6) of seventeen sampled residents was free of a significant medication error.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on February 15, 2011, with diagnoses including Chronic Pain Syndrome, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease.</p> <p>Medical record review of nurse's notes revealed on March 17, 2011, the resident was transferred to the emergency room at 5:05 p.m., due to a temperature of 100 degrees Fahrenheit, nausea and vomiting, and poor food intake during the 7:00 a.m. to 3:00 p.m. shift. Continued review of nurse's notes revealed the resident returned to the facility on March 18, 2011, at 1:00 a.m., with a</p>	F 333	<p>F 333</p> <p>Corrective Action:</p> <p>Cipro order for Resident #6 was clarified with the physician on 3/27/11 prior to the survey. Urinalysis was repeated for this resident on 3/29/11.</p> <p>Potential:</p> <p>Residents with medication orders have the potential to be affected.</p>	4-27-2011	

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			<p>Measures:</p> <p>Medication orders are to be faxed to the pharmacy. After hours, the nurse is to call the pharmacy and tell them that they are faxing a new order. The nurse is to place the medication order fax confirmation copy in the order checks notebook. The nurse is to sign off that this medication order was transcribed to the Medication Administration Record. During shift change report, the off-going nurse will report off with the on-coming nurse what new orders were received. The on-coming nurse will review the new orders in the notebook and will sign that they also checked the order for proper transcription. This process will be repeated for the next shift, so that three consecutive shifts are checking the medication orders for proper transcription to the medication administration record.</p> <p>The Director of Nursing will in-service licensed nurses regarding medication order transcription process beginning 4/13/11.</p>		

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F 333	Continued From page 31 physician's order for "Cipro (antibiotic) 500 mg (milligrams) tab (tablet) PO (orally) 1 tab BID (twice a day) for UTI (urinary tract infection)." Medical record review of the March 2011 Medication Administration Record (MAR) revealed there was no documentation the resident received the Cipro until March 27, 2011. Medical record review of physician's orders revealed a "Fax Order Request/Notification Form", noted as "priority" on March 27, 2011, at 7:55 a.m. Continued review of the "Fax Order Request ..." revealed "Pt. (patient) was Dx (diagnosed) c (with) UTI and Cipro ordered 3/18/11 500 mg PO BID. Pt. has not been given Cipro. Need new orders please. Thank you." Medical record review of physician's orders revealed a clarification order was obtained on March 27, 2011, at 3:11 p.m., for Cipro 500 mg 1 orally twice a day "till all gone". Interview with the Director of Nursing on March 29, 2011, at 10:45 a.m., in the conference room, confirmed the resident did not receive the antibiotic as ordered by the physician for nine days.	F 333	Director of Nursing, Assistant Director of Nursing or Weekend Supervisor will review order checks notebook daily for three months to ensure that the nurses are completing order checks. Monitor: The Director of Nursing will report results of order review checks to the Performance Improvement Committee during the monthly Performance Improvement Meeting for three months.		4-27-2011
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the dietary department in a clean and sanitary manner.</p> <p>The findings included:</p> <p>Observation on March 28, 2011, at 11:15 a.m., in the dietary department revealed the following: Five serving pans, used for the tray line, of various sizes, were stacked wet. Four serving pans, used for the tray line, were observed to have particles of food stuck inside the pans. Two serving pans, used for the tray line were observed to have carbon build up.</p> <p>Observation of the walk-in freezer on March 28, 2011, at 11:15 a.m., revealed one box of 8 - 10 hamburger patties which was opened and the enclosed plastic bag containing the patties was not closed. Continued observation of the walk-in freezer revealed two small cooked portions of pork roast, placed on the shelf, unwrapped and open to the air.</p> <p>Observation of the tray line food temperatures, on March 28, 2011, at 11:53 a.m., revealed the Certified Dietary Manager placed the thermometer into the foods, removed the thermometer and wiped it with a brown paper towel, between use for nine different types of food.</p> <p>Interview with the Certified Dietary Manager on March 28, 2011, at 12:30 p.m., in the kitchen, confirmed the serving pans were stacked wet/dirty/or had carbon build up; the freezer had</p>	F 371	<p>F 371</p> <p>Corrective Action:</p> <p>Pans in the dietary department were re-washed and air-dried on 3/28/11. The food was properly stored in the freezer and the cooler on 3/28/11. The leftovers were discarded on 3/28/11. The carbon build-ups on two pans were cleaned on 3/28/11. Unable to complete corrective action for the thermometer wiped with a paper towel. Dietary staff was in-serviced on 4-13-2011, proper sanitation techniques used during food temperature check process.</p> <p>Potential:</p> <p>Residents in the facility have the potential to be affected.</p> <p>Measures:</p> <p>The Regional Director of Clinical Services provided 1:1 education to the Certified Dietary Manager regarding the proper sanitation techniques used during the food temperature process on 3/30/11.</p>	

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			<p>Dietary staff was in-serviced on 4/13/11 by the Certified Dietary Manager on proper cleaning and storage of pans, proper food storage including leftovers, and the proper sanitation techniques used during the food temperature check process. Dietary staff will be in-serviced on or before 4-27-2011. The associates will not be scheduled to work the floor after 4-27-2011 until in-service is completed.</p> <p>Upon new-hire orientation, the Certified Dietary Manager in-services dietary staff on the proper cleaning and storage of pans, proper food storage including leftovers, and the proper sanitation techniques used during the food temperature check process.</p> <p>The Certified Dietary Manager completed department inspections weekly to include an opening and closing checklist.</p> <p>The Registered Dietician randomly inspects the dietary department monthly and provides the Executive Director and the Certified Dietary Manager with a written report.</p> <p>Monitoring:</p> <p>The Certified Dietary Manager will report the findings of the weekly and monthly dietary inspections to the Performance Improvement Committee during the monthly Performance Improvement Committee Meeting monthly for three months to ensure compliance.</p>		4-27-201

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F 371	Continued From page 33	F 371			
F 372 SS=F	<p>hamburger patties and the pork roast were left open to the air, and the thermometers were cleaned with a paper towel after taking the food temperatures.</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the dumpster area in a clean/sanitary manner.</p> <p>Observation on March 28, 2011, at 11:45 a.m., of the dumpster area revealed the facility had two dumpsters, one for the card board boxes and one for the trash. Continued review revealed the two doors on the dumpster, used for trash, were left open to the rain; garbage bags were left opened inside the dumpster and one bag at the door was split open allowing liquids to spill out into the track of the door and around the opening. Continued observation revealed the dumpster which contained cardboard boxes was overflowing, with boxes stacked on the outside of the dumpster, and one side of the top open to the rain. Continued observation revealed a large housekeeping trash cart used to transport trash to the dumpster, left behind the dumpsters, and was half full of water.</p> <p>Interview with the Certified Dietary Manager on March 28, 2011, at 12:30 p.m., at the dumpster area, confirmed the dumpsters were over filled,</p>	F 372	<p>Corrective Action:</p> <p>Dumpster and area was cleaned on 3/28/11.</p> <p>Potential:</p> <p>Residents in the facility have the potential to be affected.</p> <p>Measure:</p> <p>Facility has added additional waste refuse pick up to ensure sanitary Dumpster environment on April 1, 2011.</p> <p>The Certified Dietary Manager and Dietary Staff perform a Dumpster inspection daily and complete a check sheet.</p> <p>Maintenance pressure washes the Dumpster and surrounding area weekly and maintains a log.</p> <p>Monitor:</p> <p>The Certified Dietary Manager will provide a summary of results of dumpster inspections to the Performance Improvement Committee During the monthly Performance Improvement Meeting monthly for three months to ensure compliance.</p>	4-27-2011	

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F 372	Continued From page 34 the doors and the top of one dumpster left opened, with bags of gargage opened. Continued interview confirmed the area around the dumpsters were cluttered and not left in a clean and sanitary condition.	F 372			